

CHESTER J. CULVER
GOVERNOR

DEAN A. LERNER, DIRECTOR

PATTY JUDGE
LT. GOVERNOR

**DEMAND LETTER
CERTIFIED**

Incident Intake #: 31668-I

January 4, 2011

Ms. Mary Glenn, Executive Director
Emeritus at Urbandale
8525 Urbandale Avenue
Urbandale, IA 50322

**RE: I. Final Incident Investigation and Recertification Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion**

Dear Ms. Glenn:

**I. Final Incident Investigation & Recertification Report – Emeritus at Urbandale,
Urbandale, IA**

Enclosed is the **Final Incident Investigation and Recertification Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Criteria for Exclusion of Tenant, Service Plan, Medications and Tenant Rights. Emeritus at Urbandale ("Program") is being assessed a \$500 civil penalty.

DIA is accepting the Plan of Correction (POC) following the Program's submission of information. DIA is denying the Request for Reconsideration in reference to Tenant Rights.

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ADMINISTRATION
(515) 281-5457
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ADMINISTRATIVE HEARINGS
(515) 281-4843
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HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
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II. Civil Penalty

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send cover letter to the attention of **Rose Boccella** and remit the penalty assessed by check or money order in the amount of four thousand eight hundred seventy five dollars (\$4875) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0290** with effective dates of **January 12, 2011 through January 11, 2013**.

V. Conclusion

The Program is being assessed a \$7500 civil penalty. The POC submitted on December 20, 2010, has been reviewed and will constitute the final POC related to the on-site visit of November 10 and 15, 2010.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to this letter and report, please contact your Certification Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

**Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation and Recertification Report**

Assisted Living Program:

Incident Intake #: 31668-I

Mary Glenn, Executive Director
Emeritus at Urbandale
8525 Urbandale Ave
Urbandale, IA 50322

Date of Incident Investigation:

November 10 and 15, 2010

Monitor(s):

Joyce Kix, RN
Lori Miner, RN BSN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Emeritus at Urbandale on November 10 and 15, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS) : 28

Current number of tenants without cognitive disorder: 7

Total Population: 35

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – This is a dementia-specific building; no tenant meeting was held.

Program History – The program has substantiated Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenants, Service Plan, Medications, Nurse Review, Staffing, Record Checks and Other.

The complaint history during this certification period includes the complaint and incident investigation of April 28 and 29, 2009 for the Initial Certification, Complaint #22728-C and Incident #22818-I with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenants, Service Plan, Medications, Nurse Review and Staffing, which resulted in a \$500.00 fine.

The incident investigation of July 14 and 15, 2009 for Incidents #24242-I and #24244-I with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenant, Service Plan and Staffing, which resulted in a \$3,000.00 fine.

The complaint and incident revisit investigation of November 17 and 18, 2009 for Complaints #25908-C and #26312-C and the Incident Revisits of #24242-R and #24244R with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan, Medications, Staffing and Other, which resulted sanctions of a Conditional Certificate and Management Training for the Administrator and the registered nurse and a \$4,500.00 fine.

The complaint investigation of January 5 & 6, 2010 for Complaint #26904-C with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan, Staffing and Record Checks, which resulted with the sanctions remaining in a Conditional Certificate, no new tenant

admissions, Management Training for the Administrator and the registered nurse and a \$5,000.00 fine.

The complaint investigation of February 8, 2010 for Complaint #27408-C with Regulatory Insufficiencies in the areas of: Medications and Staffing, which resulted with the sanctions remaining in a Conditional Certificate, no new tenant admissions, Management Training for the Administrator and the registered nurse and a \$3,000.00 fine.

The complaint and incident revisit investigation of April 19 and 20, 2010 for Complaints #22728-C, 25908-C, 26312-C, 26904-C, 27408-C and Incident Revisits 22818-I, 24242-I and 24244-I with Regulatory Insufficiencies in the areas of: Nurse Review and Other, which resulted in a \$500.00 fine. The program was issued a standard certificate and all sanctions associated with the conditional certificate are discontinued except the registered nurse is required to submit proof of completion of the assisted living management training to DIA.

On-Site Monitoring Evaluation – The monitors made the observations detailed in the following areas.

A. Criteria for Exclusion of Tenant

- Incident Allegation: It was reported a tenant eloped from the program and tenant was unaccounted for at least four hours.
- Monitoring Observation: [REDACTED] admitted 5-17-10 with diagnoses of Alzheimer's Dementia and Hypertension (HTN). The Global Deterioration Scale (GDS) of 11-9-10 staged the tenant at four which indicated moderate cognitive decline. The clinical record contained documentation of a history and physical dated 4-22-10 which indicated the tenant had become aggressive and could not be controlled at the current facility. The documentation indicated the tenant had grabbed a female aide by the wrist and backed her into a corner. The service plan of 6-10-10 directed staff to complete safety check on all shifts since the tenant was an elopement risk. The program did not maintain documentation to verify completion of the safety checks. The service plan also documented the tenant had a history of being physically or verbally abusive, hitting others, shoving other people and using sexually inappropriate language. The nurse's note dated 5-19-10 documented [REDACTED] tenant entered two other tenant's rooms and refused to leave and got verbally aggressive as well as pounded his/her fists on chairs. The note also documented the tenant was given an intramuscular injection of an antipsychotic medication with the assistance of one nurse and four other staff members. A nurse's note dated 5-22-10 documented the tenant was found in another tenant's room and refused to get out of his/her bed. Documentation on 6-8-10 and 7-20-10 indicated the tenant was trying to get out the front door of the secured unit. On 11-7-10 at approximately 5:00 pm the tenant's family member notified the program that the police had been alerted the tenant had been at a local restaurant for the past four hours. Staff #1 reported the tenant had last been seen at lunch around 12:00 pm on 11-7-10. It is not known how or exactly when the tenant left the program. The program's maintenance person reported that Tenant #6 sits in the chair near the front door and waits for an opportunity to exit. On 11-7-10 at 10:30 am, the monitor was able to enter the nurse's station through a gate, walk through the unlocked door of the director's office and exit the building without any alarms sounding. The tenant exceeds the criteria for retention in an assisting living environment. The program was aware at admission on 5-17-10 of the tenant's aggressive behavior and elopement risk and failed to take action to initiate discharge after repeated incidents of aggression and inappropriate behavior.

During the course of the investigation, the following information was identified.

- Monitoring Observation: Tenant #1, a 77 year-old was admitted 8-23-10 with a diagnosis of Dementia. The GDS staged the tenant at six which indicated severe cognitive decline. A nurse review dated 8-24-10 indicated Ativan was not effective for restlessness and exit behaviors. The Healthcare Provider Communication Form (HPCF) dated 8-25-10 indicated Tenant #1 was wandering and going in and out of other tenants' rooms. The physician ordered Namenda (an anti-Alzheimer's agent) and Ativan (an anti-anxiety agent) was discontinued. Nurse review dated 9-9-10 indicated that on 9-3, tenant had an episode of agitation, turned over tables in dining room and urinated on them, and was emotionally labile. Tenant was described as very restless and pacing continually. Tenant responded to redirection at times, other times he/she would become agitated and have

outbursts. The registered nurse (RN) indicated behaviors were not related to significant change, but reflected what was usual for Tenant #1. Nurse review dated 9-9-10, indicated RN contacted the physician to discuss medication review and possible “geropsych” consult for Tenant #1. On 9-10-10 the HPCF indicated Tenant #1 had increased behaviors. The physician gave the following orders: Risperdal (an antipsychotic) was discontinued, Namenda (an anti-Alzheimer agent), Seroquel (an antipsychotic) and Zoloft (an antipsychotic) were ordered, and Xanax (an antianxiety agent) was increased. The order for Zoloft was written as 50mg PO every night for 1 month; then increase to 100mg PO every night. Service notes of 9-14-10 indicated that at 8:15 p.m. tenant was observed urinating on floor by front exit door. At 8:30 p.m., tenant was in the TV room, picked up a chair and threw it, almost hitting another tenant. Redirection was attempted but Tenant #1 became aggressive. At 9:00 p.m., a tenant was “very upset, walking very fast to the nurses station” and said “I need help” because a person was in his/her room. Tenant #1 was found in that tenant’s room. Staff attempted to get Tenant #1 to stand up, when he/she began kicking and trying to hit staff. Nurse review dated 9-15-10 indicated Tenant #1 had episode of agitation, with “problem behaviors” occurring in evening. Physician’s order was received for Zyprexa intramuscular injection (an antipsychotic) as needed for extreme agitation. Tenant was placed on close observation and monitoring for 72 hours. The HPCF dated 9-15-10 reported increased agitation and inappropriate behaviors which included going into other tenants’ rooms and an attempt to throw something at another tenant. The physician gave the following orders: Seroquel was increased, Xanax was increased as needed, and Zyprexa injection was ordered as needed for extreme agitation. Service notes of 9-16-10 indicated Tenant #1 pulled pants down in dining room. On 9-18-10, tenant tried to open south door. On 9-20-10, tenant was wandering and attempted to open “sun” door. On 9-21-10, tenant was sitting in hallway chair with pants down having a bowel movement. Nurse review dated 9-22-10 indicated Tenant #1 had occasional falls related to loss of balance and fast gait. No significant injuries were documented. On the HPCF dated 9-22-10, the physician documented Tenant #1 required a “higher level of care” and noted agitation, falls, increased wandering, and inappropriate behaviors which included public urination, public defecation, and the tenant exposing him/her self. Aricept (used in Alzheimer’s Dementia) was discontinued and Exelon (used in Alzheimer’s Dementia) was started. Service notes indicated on 9-27-10, while in the dining room, Tenant #1 went to another tenant’s table and took a cookie from the tenant and a cup of coffee from the tenant’s guest. Service notes of 10-4-10 indicated the RN met with the spouse of Tenant #1 to discuss concerns of “problematic behaviors.” Tenant was described as, at times, calm and easily directed, while at other times tenant was agitated and not able to be redirected. Notes indicated a discussion was held with the wife for “ICF level of dementia care services.” The HPCF dated 10-5-10 and signed by the physician on 10-8-10 indicated behaviors exhibited by Tenant #1 were better, but that the tenant may need to be transferred to a higher level of care. Service notes of 10-23-10 described Tenant #1 as anxious and restless. The tenant was found urinating on the floor and seen undressing in the dining room. The HPCF dated 10-25-10 by the physician indicated that during the weekend Tenant #1 urinated in public, masturbated, was aggressive and tried to hit staff. The physician noted that the Zoloft (an antidepressant) had been discontinued on 10-8-10 for an unknown reason. Zoloft was restarted and Seroquel (an antipsychotic) was increased. Nurse review dated 10-25-10 indicated improvement in daytime behaviors with intermittent agitation during the evening hours. Documentation indicated Tenant #1 had a recent episode of urination in the hallway as well as a “very” disruptive episode in the dining room after a meal. Documentation stated the episode of agitation was “very difficult” to manage. Dosages

of Zoloft (an antidepressant) and Seroquel (an antipsychotic) were increased at that time. On 10-27-10, tenant was restless and pacing, picking up other tenant's silverware. Tenant #1 was not easily directed. Despite medications and medication changes, Tenant #1 was dangerous to self and others. The tenant exceeds the criteria for retention in an assisting living environment

- **Regulatory Insufficiency:** A program shall not knowingly admit or retain a tenant who: Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk. (IAC r. 481-69.23(1)(c))

B. Service Plan

- **Monitoring Observation:** Nurse review dated 9-15-10 indicated Tenant #1 had an episode of agitation, with "problem behaviors" occurring in evening. Physician's order was received for Zyprexa intramuscular injection (an antipsychotic) as needed for extreme agitation. Tenant was placed on close observation and monitoring for 72 hours. On 9-17-10 functional, cognitive and health evaluations were completed and the service plan was updated. The service plan indicated the staff were to do a safety check each shift. The service plan did not contain the close observation and monitoring plan for the 72 hours or a portion thereof. The service plan contained a handwritten note that stated "see additional sheets that relate to managing and redirecting challenging behaviors." The sheets attached were a photocopy of a publication printed by the Alzheimer's Association. The service plan did not give specific direction to manage inappropriate behaviors. The service plan indicated Zyprexa injection was ordered as needed for extreme agitation. The service plan did not define under what conditions the Zyprexa was to be administered. The service plan indicated the tenant was to be reminded or encouraged to participate in activities. The service plan stated the tenant had difficulty participating in activities that required concentration. The service plan does not include planned and spontaneous activities based on the tenant's abilities and interests. The service plan does not indicate the tenant's identified needs.

The service plan for Tenant #6 dated 6-10-10 directed staff to leave the tenant for five to ten minutes when he/she is yelling and agitated, then return and approach slowly, and call for help when necessary. The service plan did not identify behaviors which would require the assistance of additional staff nor what interventions other staff were to initiate. The service plan does not identify the tenant's individualized needs.

- **Regulatory Insufficiency:** The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance; b. Any services and care to be provided pursuant to the occupancy agreement; c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; d. For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests; and e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4))

C. Medications

- **Monitoring Observation:** The HPCF dated 10-25-10 by the physician indicated that during the weekend Tenant #1 urinated in public, masturbated, was aggressive and tried to hit staff. The physician noted that the Zoloft (an antidepressant) had been discontinued on 10-8-10 for an unknown reason. Zoloft was restarted and Seroquel (an antipsychotic) was increased. The medication administration record (MAR) showed Zoloft 100mg by mouth at bedtime was to start on 10-10-10. Doses on 10-11, 10-12, and 10-13 were documented with initials and a circle around them. According to the legend on the MAR, a circle indicated a medication was refused. After 10-14-10, the MAR has a handwritten note "see new orders 10-8-10." The orders from the physician dated 10-8-10 did not discontinue the Zoloft. Zoloft 100 mg PO every night was not documented or not given 10-10-10 to 10-24-10. Orders from the physician dated 10-25-10 restarted the Zoloft 100 mg PO at bedtime. The program did not administer medication as prescribed. The program did not maintain a list of the tenant's medications.

The MAR for Tenant #6 indicated, by signature of initials, an as needed intramuscular injection was administered on 5-20-10. The nurse's notes indicated the injection was administered 5-19-10.

Tenant #6's medication orders included an order for Zyprexa intramuscular injection. The injection was to be reconstituted with sterile water. Observation of the medication cart on 11-10-10 at 2:40 pm revealed no sterile water available for the tenant's use.

- **Regulatory Insufficiency:** When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. c. The program shall maintain a list of each tenant's medications and document the medications administered. (IAC r. 481-67.5(6) (a) and (c))

D. Tenant Rights

During the course of the investigation, the following information was identified.

- **Monitoring Observation:** The HPCF dated 8-25-10 indicated Tenant #1 was wandering and going in and out of other tenants' rooms. Nurse review dated 9-9-10 indicated that on 9-3, tenant had episode of agitation, turned over tables in dining room and urinated on them, was emotionally labile. Service notes of 9-14-10 indicated that at 6:50 pm Tenant #1 was observed urinating on the floor by front exit door. At 8:30 pm, tenant was in the TV room, picked up a chair and threw it almost hitting another tenant. Redirection was attempted but Tenant #1 became aggressive. At 9:00 pm, a tenant was very upset, walking very fast to the nurse's station and indicated a person was in his/her room. Tenant #1 was found in

that tenant's room. Staff attempted to get Tenant #1 to stand up, when he/she began kicking and trying to hit staff. Service notes of 9-16-10 indicated Tenant #1 pulled pants down in dining room. On 9-21-10, Tenant #1 was sitting in hallway chair with pants down having a bowel movement. Service notes indicated on 9-27-10, while in the dining room, Tenant #1 went to another tenant's table and took a cookie from the tenant and a cup of coffee from the tenant's guest. Service notes of 10-23-10 described Tenant #1 as anxious and restless. The tenant was found urinating on the floor and seen undressing in the dining room. Nurse review dated 10-25-10 indicated Tenant #1 had a recent episode of urination in the hallway as well as a "very" disruptive episode in the dining room after a meal. Documentation stated the episode of agitation was "very difficult" to manage. On 10-27-10, Tenant #1 was restless and pacing, picking up other tenant's silverware. Tenant #1 was not easily directed. The program did not ensure all tenants were treated with consideration, respect, and full recognition of personal dignity.

The nurse's note for Tenant #6 dated 5-19-10 documented the tenant entered two other tenant's rooms and refused to leave and got verbally aggressive as well as pounded his/her fists on chairs. The note also documented the tenant was given an intramuscular injection of an antipsychotic medication with the assistance of one nurse and four other staff members. The program failed to assure all tenants' rights to be treated with consideration, respect and full recognition of personal dignity and autonomy were met.

The program occupancy agreement contained the following documentation under "Roommate": "Some residents may choose to share an apartment with a roommate who has entered into a separate agreement with us. While we make every effort to find compatible roommates and to introduce roommates prior to move-in, this may not always be possible. We reserve the right to designate which roommates move into which apartments and to transfer to different apartments for reasonable management, or other purposes such as moving a resident with limited mobility closer to the dining room or temporarily moving residents to another area during remodeling. If your roommate moves from your shared apartment, we will either assign you another roommate or assist in your transfer to another apartment."

This section of the agreement is in contradiction of the tenant's right of autonomy to choose their living arrangements.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

Dated this 29th day of November 2010.